Lakeway Eye Physicians and Surgeons, P.A.

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PATIENT REGISTRATION FORM

Name: _____ **Social Security #:** _____

Phone #: _____ **Cell** ☐ **Landline** ☐ **Phone #** _____ **Cell** ☐ **Landline** ☐

E-mail Address: _____

Address: _____
Street City State Zip

Date of Birth: ___/___/_____ **Age:** _____

Sex: M F **Marital Status:** S M D W

Employer: _____ _____ _____ _____
Name City State Zip

Occupation: _____ **Office Phone:** _____

Primary Care Physician: _____ **Optometrist:** _____

Referral Source: ☐ **Doctor** ☐ **Yelp** ☐ **Drive By** ☐ **Insurance List**
☐ **Friend/Family** ☐ **Google/Search** ☐ **Community Impact** ☐ **Other:**_____

Primary Insurance Carrier: _____

Subscriber's Name: _____ **Subscriber's Date of Birth:** _____

Subscriber's Soc. Sec. #: _____ **Relationship to Patient:** _____

- **Secondary Insurance Carrier:** _____

Subscriber's Name: _____ **Subscriber's Date of Birth:** _____

Subscriber's Soc. Sec. #: _____ **Relationship to Patient:** _____

Guarantor (The person responsible for payment if not the patient): _____

Address_____

Guarantor Date of Birth:_____**Guarantor's Soc Sec #**_____

Emergency Contact Name: _____ **Telephone #:** _____

*****ALL PAYMENTS AND CO-PAYMENTS ARE EXPECTED AT TIME OF SERVICE*****

PATIENT MEDICAL HISTORY **Date: _____**

Name: _____ Date of Birth: _____

Are you ALLERGIC to any medications (Describe)? Y N_____

Are you currently taking ANY medications (Describe)? Y N_____

_____

Are you currently taking any EYE medications (Describe)? Y N_____

Do you wear glasses? Y N **Do you wear contact lenses? Y N** **soft ☐** **hard ☐**

Do you have any history of eye disease (Describe)? Y N _____

Have you ever had an eye injury or eye surgery? (Describe & include year) Y N _____

Do you have or have you had any of the following conditions or problems? (PLEASE CIRCLE)

- **Constitutional: weight loss/gain, fatigue, etc.**
- **Ear/Nose/Throat: hearing loss, sinus problems**
- **Cardiovascular: high blood pressure, heart problems, heart attacks, pacemaker**
- **Endocrine: diabetes, thyroid problems, Graves disease**
- **Hematologic/Lymphatic: HIV+, AIDS, hepatitis, high cholesterol**
- **Respiratory: asthma, emphysema, bronchitis, tuberculosis**
- **Gastrointestinal: heartburn, ulcer**
- **Integumentary: rashes, rosacea, breast problems, healing problems/keloid formation**
- **Musculoskeletal: arthritis, lupus, gout, osteoporosis**
- **Neurological: headaches, stroke, multiple sclerosis, paralysis**
- **Psychiatric: depression, anxiety, claustrophobia**
- **Allergic/Immunologic: seasonal allergies, hay fever**

If you circled any of the above conditions, please describe your condition or problems: _____

_____

Have you ever had any head injuries? (Describe & include year) Y N _____

Have you ever had other surgeries (not including eyes)? (Describe & include year) Y N_____

_____

Do you have any FAMILY HISTORY of the following? If so, please list relationship (mother, grandfather, etc.)

Y N Blindness: _____ Y N Cancer: _____

Y N Cataracts: _____ Y N Diabetes: _____

Y N Diabetic Retinopathy: _____ Y N Heart Disease: _____

Y N Glaucoma: _____ Y N High Blood Pressure: _____

Y N Macular Degeneration: _____ Y N Stroke: _____

Y N Retinal Detachment: _____ Y N Other (explain): _____

Are you currently a smoker? Y N **Former Smoker? Y N** **Recreational or Cannabinoid use? Y N**

Number of years and amount per day: _____

Do you drink alcohol? ☐ none ☐ rarely ☐ socially ☐ daily: drinks per day: ____